INPATIENT HOSPITAL PAYMENT METHODOLOGY

GENERAL

The South Dakota Medicaid program has been reimbursing hospitals for inpatient services, with a few exceptions, under a prospective Diagnosis Relate Group (DRG) methodology since January 1, 1985. South Dakota uses the federal definitions of DRGs, DRG classifications, weights, geometric mean lengths of stay, and outlier cutoffs as used for the Medicare prospective payment system. The DRG grouper program is updated annually as of October 1 of each year, beginning with the Medicare grouper version 15 (effective October 1, 1997). The State agency calculates Medicaid Program specific weight and geometric mean length of stay factors annually using the latest three years of non-outlier claim data, this three year claim database updated annually in order to establish new weight and geometric length of stay factors with each new grouper.

The agency developed hospital specific costs per Medicaid discharge amounts for all instate hospitals using Medicare cost reports and non-outlier claim data for the hospitals' fiscal years ending after June 30, 1996 and before July 1, 1997. The agency applied an inflation factor, specific to each hospital's fiscal year end, to the cost per discharge amounts of all hospitals with more than thirty (30) Medicaid discharges during the base year to establish target amounts for the period of October 1, 2010 through September 30, 2011. There is a cap on the hospitals' target amounts, under which no hospital is allowed a target amount that exceeds 110% of the statewide weighted average of all target amounts.

South Dakota Medicaid reimburses out-of-state hospitals on the same basis as the hospital is paid by the Medicaid agency in the state in which the hospital is located. If the hospital's home state refuses to provide the amount they would pay for a given claim, the payment will be at 50% of billed charges. Payment will be for individual discharge or transfer claims only; there will be no annual cost settlement with out-of-state hospitals or with instate DRG hospitals unless an amount is due the South Dakota Medicaid program.

For claims with dates of service from July 1, 2011 through June 30, 2012, the amount of reimbursement for instate DRG hospitals and all out-of state hospitals, will be reduced by 11.48 percent after any cost sharing amount due from the patient, any third party liability amounts have been deducted, and other computation of any cost outlier payment. This does not apply to South Dakota hospitals that are determined by the Department of Health to be above average access-critical or above average at-risk.

SPECIFIC DESCRIPTION

The agency calculates a hospital's target amounts for non-outlier claims by dividing the hospital's average cost per discharge for non-outlier claims by the hospital's case mix index. To ensure budget neutrality, the agency adjusts annually a hospital's target amount for any change in that hospital's case mix index resulting from the establishment of new program specific weight factors. For each hospital, the case mix index is the calculated result of accumulating the weight factors for all claims submitted during the base period and dividing by the number of claims.

The average cost per discharge for non-outlier claims was calculated by subtracting the charges for ancillary services on outlier claims, multiplied by the average ancillary cost to charge ratio, from the total allowable ancillary charges for the hospital. Total Medicaid days and discharges were reduced by the number of days and discharges from outlier claims to calculate the routine costs for non-outlier claims. Routine costs and ancillary costs related to non-outlier claims were added and then the total allowable costs were divided by the number of non-outlier discharges during the base period.

CAPITAL COSTS

Interim payments for capital and education costs will be made to instate hospitals that had more than thirty (30) Medicaid discharges during the hospitals' fiscal year ending after June 30, 1996 and before July 1, 1997 on a per diem basis. The agency will calculate hospital-specific interim rates using the most recently reviewed Medicare cost report, with reimbursements being reduced 11.48% for the year beginning July 1, 2011, and ending June 30, 2012. This does not apply to South Dakota hospitals that are determined by the Department of Health to be above average access-critical or above average at-risk, or for hospitals designated as Critical Access by Medicare.

TRANSFER PATIENTS

Payment will be allowed to the transferring hospital whenever a patient is transferred to another hospital regardless of whether the receiving hospital is paid under the DRG system or is an exempt hospital or unit.

The amount of payment made to the transferring hospital will be on a per diem basis. The per diem rate will be calculated by dividing the standard DRG payment for the particular stay by the geometric mean length of stay for the DRG. The per diem rate will then be multiplied by the number of days stay prior to the transfer. In no instance will the payment to the transferring hospital be any higher than the full DRG payment amount if the patient had been discharged home. The daily capital/education pass-through will be added to the DRG payment.

The receiving hospital will be paid a normal DRG payment unless the patient is again transferred to another hospital.

COVERED DIAGNOSTIC RELATED GROUPS

South Dakota will adopt all DRGs, except DRG 522, established in the version of the grouper program being used by the Department as of the admission date on the claim.

5. Rehabilitation Units (only upon request and justification);
6. Children's Care Hospitals;
7. Indian Health Service Hospitals,
8. Hospitals with less than 30 Medicaid discharges during the hospital's fiscal year ending after June 30. 1993, and before July 1, 1994; and
9. Specialized Surgical Hospitals.

Payment for the above instate exempt facilities and/or units, except for psychiatric hospitals, psychiatric units, Indian Health Service Hospitals, specialized surgical hospitals, and instate hospitals with less than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1993, and before July 1, 1994, will continue on the Medicare retrospective cost base system with the following exceptions.

1. Costs associated with certified registered nurse anesthetist services that relate to exempt hospitals and units will be included as allowable costs.
2. Malpractice insurance premiums attributable to exempt units or hospitals will be allowed using a 7.5% of the risk portion the premium multiplied by the ratio of inpatient charges to total Medicaid inpatient charges for these hospitals or units.

Psychiatric hospitals, psychiatric units, rehabilitation hospitals, rehabilitation units, perinatal units, and children's care hospitals will be paid on a per diem basis based on the facility's reported, allowable costs as established by the State. This per diem amount will be updated annually as directed by legislature based on review of economic indices and input from interested parties not to exceed the rate as established by the medical care component of the Consumer Price Index of the most recent calendar year.

Specialized Surgical Hospitals will be reimbursed on a per diem basis equal to twice the per diem rate allowable for swing-bed hospitals as established in Attachment 4.19-D – Other, Provision 10.

Indian Health Service hospitals will be paid on a per diem basis as established by CMS.

Instate hospitals with less than 30 discharges during the hospital's fiscal year ending after June 30, 1993, and before July 1, 1994, will be paid 95% of billed charges.

For claims with dates of service from July 1, 2011, through June 30, 2012, the amount of reimbursement for psychiatric hospitals, rehabilitation hospitals, perinatal units, psychiatric units, rehabilitation units, and specialized surgical hospitals will be reduced 11.48 percent, and payments for children's care hospitals will be reduced by 4.5%, after any cost sharing amount due from the patient, any third party liability amounts have been deducted, and other computation of any cost outlier payment.

EXCEPTION TO PAYMENT METHODOLOGIES FOR ACCESS-CRITICAL AND AT-RISK HOSPITALS

Hospitals that have been determined by the Department of Health to be above average access-critical and above average at-risk will be reimbursed at the greater of actual allowable cost or the payment received under the provisions contained in this Attachment.

UPPER LIMITS

The State has in place a public process which complies with the requirements of Section 1902 (a) (13) (A) of the Social Security Act.

Psychiatric Residential Treatment Facilities

The Department will pay facilities based on a per diem rate prospectively calculated based upon the State fiscal year. The Department will use the same methodology for governmental and private facilities.

Providers must submit a cost report on forms designated by the Department identifying allowable costs incurred during the fiscal year. The Department will calculate rates for the facilities based upon each facility's actual allowable costs. Allowable costs include those costs that are ordinary, necessary, reasonable, and adequate to meet costs incurred by those facilities that are related to resident care services in conformance with State and Federal laws and regulations. Allowable cost centers include salaries and benefits for facilities' personnel, payroll taxes, professional fees and contract services, travel/transportation, supplies, occupancy, equipment, depreciation, and other. Non-allowable costs include bad debt, advertising, public relations, and costs not incurred by the facility including the value of donated goods and services.

Providers must maintain a daily census report that identifies the number of residents that received services on any particular day. The Department divides allowable and reasonable costs by the census data to calculate the payment rate for the next rate setting period. The census data for a resident is limited to those days in which the resident is actually present in the facility, and is subject to audit by the Department to verify its accuracy in conjunction with the submitted cost report.

Each facility must submit an annual Department-approved cost report by September 30 of each year identifying actual, previous State fiscal year historical costs. All cost reports are subject to desk review by the Department. If audit adjustments are made, the facility is notified immediately either by telephone, in writing, or electronic mail. The Department will establish desk audit rates for each facility based on the cost report desk review.

The Department calculates the final rate using a minimum occupancy limit of 90% so facilities with occupancy less than 90% will receive per diem rates based upon 90% occupancy. The rate calculated is considered payment in full for all allowable services delivered by the provider to eligible Medicaid recipients.

The Department will pay out-of-state facilities based upon the rate for comparable services established by the Medicaid agency in the state where the facility is located. If no rate is established by the Medicaid agency in that state, then the per diem rate payable to the out-of-state facility will be the lower of billed charges or the average of the per diem rates in effect for in-state facilities at the time the services are first provided by the out-of-state facility, except that a per diem rate higher than the average per diem rate may be negotiated by the Department for extraordinary or unusual circumstances on a case-by-case basis. Negotiated per diem rates may not exceed the cost of the services provided by the facility.